

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN3304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/02/2013
NAME OF PROVIDER OR SUPPLIER  HEALTH CENTER AT STANDIFER PLACE, THE		STREET ADDRESS, CITY, STATE, ZIP CODE 2626 WALKER RD CHATTANOOGA, TN 37421		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the survey, there were no deficiencies cited from 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Administrator

(X6) DATE

4-17-13

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN3304	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - BUILDING 02  B. WING: _____		(X3) DATE SURVEY COMPLETED  04/02/2013
NAME OF PROVIDER OR SUPPLIER  HEALTH CENTER AT STANDIFER PLACE, THE			STREET ADDRESS, CITY, STATE, ZIP CODE 2626 WALKER RD CHATTANOOGA, TN 37421		
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Administrator

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STATE FORM

5909

W34Z21

If continuation sheet 1 of 1